

# ACAP

*Association for Community Affiliated Plans*

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James Hooley, Chairman · Margaret A. Murray, Executive Director

**Statement of  
Margaret A. Murray, Executive Director  
Association for Community Affiliated Plans (ACAP)  
to the  
Senate Special Committee on Aging  
  
On Equalizing the Medicaid Drug Rebate Between  
Medicaid Fee-for-Service and Medicaid Managed Care**

**July 20, 2005**

*ACAP Mission: To improve the health of vulnerable populations through the support of Medicaid-focused community affiliated health plans committed to these populations and the providers who serve them.*

## **Introduction**

Chairman Smith, Senator Kohl, members of the Committee, thank you for the opportunity to testify today before the Senate Special Committee on Aging. My name is Meg Murray and I am the Executive Director of the Association for Community Affiliated Plans (ACAP). Before I begin, I want to thank you for holding this hearing. The Medicaid program is a vital source of care for more than 40 million Americans and it is important that Congress do everything it can to properly understand its complexities and nuances as it looks to change the program. Hearings like this go a long way in fostering a greater understanding of Medicaid.

Thank you.

ACAP seeks to offer a positive contribution to the national discussion over reforming the Medicaid program. ACAP believes that Medicaid is a critical component of America's health care safety net. However, we also recognize that certain aspects of the 40-year-old program are in need of modernization. As a result, ACAP brings to Congress a proposal that would change Federal law to equalize access to the Medicaid drug rebate between fee-for-service and managed care, thereby modernizing the program and providing State and Federal governments with substantial savings.

## **About ACAP and Safety Net Health Plans**

ACAP is a national trade association representing "safety net health plans" that are Medicaid-focused (75% of the plans' enrollees have Medicaid or SCHIP coverage) and are non-profit or owned by non-profit entities like public hospitals or community health centers. ACAP's mission is to improve the health of vulnerable populations through the support of Medicaid-focused community affiliated health plans committed to these populations and the providers who serve them.

As of July 2005, ACAP represents 19 plans serving 2.1 million Medicaid beneficiaries in 12 states. ACAP plans serve one of every six Medicaid managed care enrollees. I have included a list of ACAP's member health plans at the end of my written statement for your review.

## **Support for Common Sense Medicaid Reform**

ACAP has taken a strong and consistent position in discussions on Medicaid that the 40 year old program is in need of reform and improvement, but the essential elements of Medicaid must be maintained – coverage of comprehensive health care services, the entitlement to coverage for those categorically and income needy, and the essential oversight and partnership role that the Federal government shares with the States.

In addition, ACAP has consistently opposed making changes in Medicaid solely to meet arbitrary budget targets. Although ACAP understands the need for and

supports fiscal responsibility, we also understand that Medicaid provides essential services for the most needy Americans – most of whom would otherwise have little access to health care coverage if not for Medicaid. In this case, cuts in the program mean cuts to people. ACAP has always supported a discussion of Medicaid reform outside the scope of the budget process (or at least that was not driven by the budget process) and will continue to believe that changes in the program should be made in the best interest of the people who need its services.

### **How Safety Net Plans Manage Drug Costs While Maintaining Quality of Care**

Prescription drug utilization management is an important tool plans use to improve the quality of care to beneficiaries and control costs. Plans employ a range of drug management tools that allow them to coordinate and fully manage all aspects of beneficiaries' care. For example, drug utilization management allows plans to identify who may need prenatal services and to track use by disease or high use so plans can assist beneficiaries in managing chronic conditions such as diabetes or HIV. It also provides plans with a way to identify potential problems such as drug interactions. Plans are able to strike the right balance between appropriate use of generics and situations where brand prescription drugs are medically appropriate.

In January 2003, the Center for Health Care Strategies (CHCS) published a report entitled *Comparisons of Medicaid Pharmacy Costs and Usage between the Fee-for-Service and Capitated Setting*<sup>1</sup>. The report concludes that the MCOs are able to reduce their average per member per month (PMPM) drug costs for families in Medicaid managed care to \$17.36 compared to \$20.46 in the state fee-for-service programs. The report postulates that although the MCOs are at a price disadvantage due to their inability to access the federal Medicaid drug rebate program, they make up the price disadvantage by paying less in dispensing fees, using more generics and other lower cost drugs, and lowering the number of prescriptions per month. These figures suggest that pharmacy costs in the FFS Medicaid setting end up 18 percent higher than in the managed care setting even though plans are at a disadvantage with respect to the federal rebate.

In addition, the report also made the following findings with respect to Medicaid managed care and prescription drugs:

- The pre-rebate ingredient prices paid for medications are similar in both FFS and managed care settings. Due to federal rebate that is triple those received by the health plans, the average post-rebate price of a given drug in the FFS setting is 16 percent lower than the same drug in the managed Medicaid setting.

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<sup>1</sup> [http://www.chcs.org/grants\\_info3963/grants\\_info\\_show.htm?doc\\_id=206522](http://www.chcs.org/grants_info3963/grants_info_show.htm?doc_id=206522)

- Managed care organizations (MCOs) typically pay much lower dispensing fees to pharmacies than do state Medicaid agencies. This lowers the FFS price advantage from 16 percent to 12 percent.
- MCOs further lower the average price paid for prescription drugs by influencing the mix of drugs vis-à-vis the mix that occurs in FFS. For example, 59 percent of MCO TANF prescriptions were for generic products, versus 50 percent of FFS prescriptions. Once the mix of drugs is taken into account, the overall price advantage of the FFS setting is only six percent.
- The TANF usage rate of drugs is 15-20 percent lower in the managed Medicaid setting than in FFS Medicaid.
- Overall TANF per member per month costs of the pharmacy benefit are 10 to 15 percent lower in the capitated (Medicaid MCO) setting than in FFS Medicaid. Thus, while health plans start out roughly at a price disadvantage of 15 percentage points due to the rebate differential, health plan benefits management efforts completely turn the equation around. The MCOs end up paying significantly less than FFS in terms of final PMPM pharmacy costs.

CHCS concluded that these findings may have several policy implications. For example, the findings appear to support including – rather than carving out – pharmacy in the MCOs' capitation rates. The findings also can serve as a starting point in quantifying the level of system savings that might be achieved by extending the FFS rebate to MCOs, as well as the level of FFS savings that might be achieved if states adopt some of the pharmacy benefits management techniques that are proving effective in the capitated Medicaid setting.

## **Congress Should Equalize the Medicaid Drug Rebates Between Medicaid Fee-for-Service and Managed Care**

Created by OBRA 1990, the Medicaid Drug Rebate Program requires drug manufacturers to have rebate agreements with the Secretary of Health and Human Services for States to receive federal funding for outpatient drugs dispensed to Medicaid patients as part of their fee-for-service programs. At the time the law was enacted, health plans were excluded from access to the drug rebate program. In 1990, only 2.8 million people were enrolled in Medicaid health plans and so the savings lost by the exclusion were relatively small. Today, *12 million people are enrolled in capitated health plans*. Even though managed care plans pay higher prices for drugs due to the inequities of the drug rebate, they still pay less on a PMPM basis because of their better utilization management techniques. Equalizing access to the drug rebate would allow plan to pay even less for drugs on a PMPM basis.

Through the drug rebate, States receive between an 18 and 20% discount on brand name drug prices and between 10 and 11% for generic drug prices. According to a study by the Lewin Group for ACAP and other Medicaid-focused health plans, Medicaid-focused MCOs typically only receive about a 6% discount on brand name drugs and no discount on generics<sup>2</sup>. Because the Medicaid fee-for-service program is required by law to get the best and lowest price via the drug rebate mechanism, Medicaid managed care plans end up paying higher prices for the drugs even though they are also serving Medicaid beneficiaries. That is why ACAP believes that equalizing the drug rebate program between fee-for-service and managed care provides States with the best of both worlds – allowing plans to continue managing drug utilization while also obtaining access to the lower costs drugs through the drug rebate.

### **MCOs' Lack of Access to Medicaid Drug Rebate May Force States to Make Bad Long Term Budget Decisions**

The inability of health plans to access the Medicaid drug rebate has caused some states to carve prescription drugs out of the capitated payments to the plans to retain access to the drug rebate – thereby eliminating the ability of health plans to engage many of the innovative drug utilization programs that maintain continuity and appropriateness of care and control drug costs. Currently 12 states<sup>3</sup> with a combined Medicaid managed care population just below three million carve drugs out of their capitation payments.

In November 2003, the Lewin Group issued a report entitled *Analysis of Pharmacy Carve-Out Option for the Arizona Health Care Cost Containment System* for

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<sup>2</sup><http://www.communityplans.net/publications/Working%20Papers/Lewin%20II%20report%20FINAL%20REPORT.pdf>

<sup>3</sup> Those states are Delaware, Iowa, Maine, Nebraska, New Hampshire, New York, North Carolina, North Dakota, Tennessee, Texas, Utah, and West Virginia.

the Center for Health Care Strategies.<sup>4</sup> In their report, Lewin found that “Pharmacy costs in the AHCCCS program are the lowest that have been achieved in the Medicaid setting. Arizona’s PMPM costs for aged, blind, and disabled eligibles were found to be the lowest in the nation, 38 percent below the national Medicaid average (after taking into consideration the large rebates other states receive)...Based on our qualitative and quantitative research, **we attribute this performance to the AHCCCS health plans.**”

At the time of the report, Arizona had been considering carving prescription drugs out of the control of the Medicaid health plans in an effort to generate savings from the Medicaid drug rebate. Lewin addresses this in their report...

*“In modeling the impacts of a carve-out, we estimated the incremental value of the federal rebates under a carve-out to be approximately \$40 million annually. (This incremental value is the amount by which the federal rebate revenue would exceed the rebate revenues obtained by the health plans in FFY 2002.)...Our best estimate is that offsetting costs (including administrative costs and costs associated with a changing drug mix and volume) will exceed the \$40 million in rebate savings, **resulting in net annual costs of a carve-out of approximately \$3.7 million in state funds.** At a projected \$7 million, net administrative costs are significant but not the driving cost factor associated with a carve-out. The key costs projected are those associated with a more expensive volume and mix of drugs that are likely to result under a carve-out.”*

In short, Lewin found that Arizona would actually have lost money if it had carved prescription drugs out of the capitated payments to the plans because the State would have removed beneficiaries from the health plans’ drug management programs and exposed them to less coordinated and managed systems of care.

### **Opportunity to Save Federal and State Governments Medicaid Dollars**

We also believe that this proposal will generate savings for Federal and State governments. The Lewin study found that giving health plans access to the drug rebate could save Federal and State governments up to \$2 billion in Medicaid savings over 10 years. ACAP actually believes that the savings could exceed \$2 billion because more states are turning to managed care in their states and the report is several years old. We are prepared to continue working with the Congressional Budget Office to identify the scorable savings from the proposal.

As such, we believe that this drug rebate proposal can play an important role in the discussions that are currently being had in Congress about how to arrive at the \$10 billion in savings that must be produced as a result of budget reconciliation. Although this proposal will not generate all of the savings, we believe that it can contribute to the savings or offset the costs of new Medicaid spending that may be included in the reconciliation package. Ultimately, we hope that this proposal will provide some relief to

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<sup>4</sup> [http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=211308](http://www.chcs.org/publications3960/publications_show.htm?doc_id=211308)

Federal policymakers who are forced to make tough decisions about where to save money in Medicaid.

We also want to reiterate that there is no guaranteed benefit to the Medicaid health plans. In the most likely scenario, States will reduce the capitated payments to the plans to take advantage of the savings generated by the rebate. While we recognize this, we also hope that states will reinvest a portion of the savings generated under this policy change to provide for quality improvement initiatives to beneficiaries enrolled in Medicaid managed care plans. As partners with the States, we believe that this is a reasonable (although not mandated) position that will continue to help strengthen the Medicaid health plan delivery system.

### **Support Among State Policymakers and the Medicaid Managed Care Industry**

In an effort to raise awareness of this proposal, ACAP has been very active in talking to Medicaid stakeholders about this proposal. We are very pleased with how well this proposal has been received. It has been endorsed by organizations representing both state government and the managed care industry, including the:

- National Governors' Association;
- National Association of State Medicaid Directors;
- Medicaid Health Plans of America;
- Association for Community Affiliated Plans; and
- National Association of Community Health Centers.

I have included several of these endorsement letters and policies at the conclusion of this statement. In short, we believe that this widespread support demonstrates that this drug rebate proposal is a common-sense idea that will modernize the program and help policymakers generating Medicaid savings without being divisive or threatening critical health care services.

### **Conclusion**

At this time when Congress is forced to make tough decisions to identify savings in the Medicaid program, ACAP believes that this proposal to equalize Medicaid health plans' access to the drug rebate makes sense. This proposal will modernize the program, save billions of dollars in Federal and State Medicaid expenditures, and will not force the elimination of needed benefits or force beneficiaries off the rolls. Because of this, we urge the inclusion of this provision in any Medicaid reform or reconciliation language produced by the Senate.

This concludes my statement and I would be happy to answer any questions the Committee may have. Thank you.

**Short Biography for Meg Murray, Executive Director  
Association for Community Affiliated Plans (ACAP)**

***Margaret A. Murray, MPA,*** Meg Murray is the Executive Director of the Association for Community Affiliated Plans. Her previous experience with healthcare finance includes serving as the Medicaid Director for the New Jersey Department of Human Services, as the Senior Program Examiner for the Office of Management and Budget, and as the Senior Associate at the Alpha Center. She has also held public finance positions including Tax Legislative Analyst for Senator Bill Bradley and Revenue Director for the Massachusetts House Ways and Means Committee. She received her MPA from the Woodrow Wilson School of Public and International Affairs at Princeton University and her BA from Wellesley College.



### **ACAP Member Plans as of May 2005**

Affinity Health Plan Ms. Maura Bluestone 2500 Halsey Street Bronx, NY 10461	Commonwealth Care Alliance Dr. Robert Master 30 Winter Street, 9th Floor Boston, MA 02108
Alameda Alliance for Health Ms. Ingrid Lamirault 1240 South Loop Road Alameda, CA 94502	Community Choice Health Plan Ms. Le'Dice Murphy 30 South Broadway Yonkers, NY 10701
AlohaCare Mr. John McComas 1357 Kapiolani Boulevard, Suite 1250 Honolulu, HI 96814	Community Health Network of Connecticut Ms. Sylvia Kelly 11 Fairfield Blvd. Wallingford, CT 06492
CareOregon Mr. David Ford 522 SW Fifth Avenue, Suite 200 Portland, OR 97204	Community Health Plan of Washington Mr. Darnell Dent 720 Olive Way, Suite 300 Seattle, WA 98101-9619
CareSource Ms. Pam B. Morris One S. Main Street Dayton, OH 45402-2016	Health Plus Prepaid Health Systems Mr. Tom Early 335 Adams Street, 26th Floor Brooklyn, NY 11201
Colorado Access Mr. Donald Hall 10065 East Harvard Street Denver, CO 80231	Health Right, Inc Ms. Patrina Fowler 1101 14th Street, NW Suite #900 Washington, DC 20005
Monroe Plan for Medical Care, Inc. Mr. Bob Thompson 2700 Elmwood Avenue Rochester, NY 14618	Hudson Health Plan Ms. Georganne Chapin 303 South Broadway, Suite 321 Tarrytown, NY 10591
Network Health Allan Kornberg 432 Columbia Street, Suite 23 Cambridge, MA 02141	Neighborhood Health Plan of Massachusetts Mr. James Hooley 253 Summer Street Boston, MA 02210
Total Care Mr. Ruben Cowart 819 South Salina Street Syracuse, NY 13202	Neighborhood Health Plan of Rhode Island Mr. Ernest Balasco, Interim 299 Promenade Street, Providence, RI 02908
Virginia Premier Health Plan, Inc. Mr. James Parrott P.O. Box 5307 Richmond, VA 23220-0307	



National Association of State Medicaid Directors

**Policy Statement:**  
**MCO Access to the Medicaid Pharmacy Rebate Program**

**Background**

The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) established a Medicaid drug rebate program that requires pharmaceutical manufacturers to provide a rebate to participating state Medicaid agencies. In return, states must cover all prescription drugs manufactured by a company that participates in the rebate program. At the time of this legislation, only a small percentage of Medicaid beneficiaries were enrolled in capitated managed care plans and were primarily served by plans that also had commercial lines of business. These plans requested to be excluded from the drug rebate program as it was assumed that they would be able to secure a better rebate on their own. Though regulations have not yet been promulgated, federal interpretation to date has excluded Medicaid managed care organizations from participating in the federal rebate program.

Today, the situation is quite different. 58% of all Medicaid beneficiaries are enrolled in some type of managed care delivery system, many in capitated health plans. Some managed care plans, especially Medicaid-dominated plans that make up a growing percentage of the Medicaid marketplace, are looking at the feasibility of gaining access to the Medicaid pharmacy rebate. However, a number of commercial plans remain content to negotiate their own pharmacy rates and are not interested in pursuing the Medicaid rebate.

**Policy Statement**

The National Association of State Medicaid Directors is supportive of Medicaid managed care organizations (MCOs), in their capacity as an agent of the state, being able to participate fully in the federal Medicaid rebate program. To do so, the MCO must adhere to all of the federal rebate rules set forth in OBRA '90 and follow essentially the same ingredient cost payment methodology used by the state. The state will have the ability to make a downward adjustment in the MCO's capitation rate based on the assumption that the MCO will collect the full rebate instead of the state. Finally, if a pharmacy benefit manager (PBM) is under contract with an MCO to administer the Medicaid pharmacy benefit for them, then the same principal shall apply, but in no way should both the MCO and the PBM be allowed to claim the rebate.

*Approved by NASMD June 24, 2002*



*Ensuring Access to Better Healthcare*

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April 7, 2005

Margaret A. Murray, Executive Director  
Association for Community Affiliated Plans  
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Dear Ms. Murray:

The Medicaid Health Plans of America (MHPOA) supports your proposed initiative to provide Medicaid managed care organizations with access to the Medicaid drug rebate found in Section 1927 of the Social Security Act. We support this effort and urge Congress to enact this common sense provision.

Medicaid Health Plans of America, formed in 1993 and incorporated in 1995, is a trade association representing health plans and other entities participating in Medicaid managed care throughout the country. Its primary focus is to provide research, advocacy, analysis, and organized forums that support the development of effective policy solutions to promote and enhance the delivery of quality healthcare. The Association initially coalesced around the issue of national healthcare reform, and as the policy debate changed from national healthcare reform to national managed care reform, the areas of focus shifted to the changes in Medicaid managed care.

Your proposal to allow Medicaid managed care organizations access to the Medicaid drug rebate makes sense given the migration of Medicaid beneficiaries from fee-for-service to managed care since 1990. Increasingly, states have not been able to take advantage of the drug rebate for those enrollees in managed care, thus driving up federal and state Medicaid costs. The savings estimated in the Lewin Group study are significant and may help to mitigate the needs for other cuts in the program. In addition, it demonstrates a proactive effort to offer solutions to improving the Medicaid program. We applaud this effort.

MHPOA is proud to support this legislative proposal and will endorse any legislation in Congress to enact this proposal.

Sincerely,

Thomas Johnson  
Executive Director

**Excerpt from National Governors Association's June 15, 2005  
Medicaid Reform: A Preliminary Report (pages 3 – 4):**

*“Governors believe that the burden of reducing Medicaid expenditures for prescription drugs will require a multi-prong approach and should include savings proposals that affect both drug manufacturers and retail pharmacists, as well as increase state utilization management tools that decrease inappropriate prescribing and utilization. It is critical that states maintain and enhance their ability to negotiate the best possible prices with the industry.*

*There may be benefits of using ASP or other calculations as a reference price, because increased transparency of drug costs can serve to decrease total costs, especially if there is more flexibility with respect to dispensing fees (they should not be tied to a percentage of the cost of the drug dispensed, for example.)*

*This proposal should be modified in several ways...*

- *Allowing managed care organizations to access Medicaid rebates directly for the Medicaid populations that they serve.”*